Grand Bend Area Community Health Centre
Every One Matters.

DE-4.0 – Diabetes Education and Management Referral Form

Date: _____ Health Card #: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Hone Phone: _____ Work Phone: _____

Type of Diabetes:

☐ New Diagnosis (< 1yr) ☐ Type 1 Diabetes ☐ Prediabetes
☐ Established (> 1yr) ☐ Type 2 Diabetes ☐ At Risk for Diabetes

Reason for Referral:

☐ Meal Plan/Nutrition Education ☐ Insulin Start ☐ Blood Pressure Class
☐ General Diabetes Education ☐ Prediabetes Class ☐ Heart Health Class
☐ Diabetes/Chronic Disease Prevention Class

LAB DATA:
Please attach recent blood work - within past 3 months (i.e. HbA1c, Lipids, Glucose, etc. …)

Diabetes Medications	**All Other Medications**

Other Related Health Problems:

☐ Retinopathy ☐ Neuropathy ☐ Psychosocial ☐ Smoker ☐ Nephropathy
☐ Overweight ☐ Foot Problems ☐ CAD ☐ HTN ☐ Exercise Restrictions
☐ Other _____

Physician / Nurse Practitioner Referring: _____

Address: _____ Postal Code: _____

Phone Number: _____ Fax Number: _____

Signature of Referring Physician / Nurse Practitioner _____

Form Adapted from the Lawson Diabetes Centre Diabetes Education Referral Form